

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33284
State File No. _____
Registrar's No. 7595

FILE OCT 2 1952

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7595	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY ST. LOUIS			
b. CITY (If outside corporate limits, write RURAL and give township) St Louis				c. CITY (If outside corporate limits, write RURAL and give township) Affton			
c. LENGTH OF STAY (In this place) 12 WKS				d. STREET ADDRESS 4739 Seibert			
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros Hospital				e. (If rural, give location) 1			
3. NAME OF DECEASED (Type or Print) Edward		a. (First)		b. (Middle)		c. (Last) O'Connell	
4. DATE OF DEATH Aug. 8, 1952		5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED married	
8. DATE OF BIRTH May 26, 1885		9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Daniel O'Connell		13b. MOTHER'S MAIDEN NAME Sophie Spitz		14. NAME OF HUSBAND OR WIFE Esbia O'Connell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 488-01-9867A		17. INFORMANT'S SIGNATURE OR NAME Esbia O'Connell			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cachexia (b) Metastasis (c) Carcinoma of Prostate II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 177X					
22. I hereby certify that I attended the deceased from July 1, 1952 to Aug 8 1952 that I last saw the deceased alive on Aug 8, 1952, and that death occurred at 6:00 P.M., from the causes and on the date stated above.							
23a. SIGNATURE Stephen M. Tappan M.D.				23b. ADDRESS 818 Olive		23c. DATE SIGNED Aug 9, 1952	
24a. BURIAL, CREMATION, REMOVAL REMOVAL		24b. DATE 8/12/52		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) Affton Mo	
DATE REC'D BY LOCAL REG. AUG 9 1952		REGISTRAR'S SIGNATURE J. C. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J L Ziegenhein & Sons 7027 Gravois			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Neville B. Prohutter

Licensed Embalmer No. *3696*

P. O. Address *7027 Gravois*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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